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A. Well, the Table 3 was identified to find drugs that were sufficiently unique that when they launch they -- their -- they did not need to offer spread in order to -- to -- they did not need to make use of a -- a discount off of AWP that was not understood by the market to achieve market penetration.

So, these were drugs like Prilosec. It was the first Proton pump inhibitor or Closaril. It was the first atypical antipsychotic. And I was looking for drugs here where they were the first drug in the market. This is a case where they did not need to compete on spread, either nontransparently or transparently, and this is a case where you'd see a relationship between AWP as a signal for the transactions prices, i.e., for drugs not requiring a nontransparent competition on spread.

Now if Pravachol -- these were a set of indications and a set of problems where drugs could be identified, and I asked some of our consultants at the Harvard School of Public Health to identify

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different areas where there were drugs of that sort and -- and I -- I took, as my point of departure, their identification of those lists. Pravachol must not have appeared on any of those lists. It was not dropped for any reason where it was singled out. I -- I began this process by identifying what were -- were drugs that didn't need any kind of fraudulent spread competition. And I tried to get the data on these drugs, and obviously, I couldn't get the data on all of these drugs. And some of them are good -- in Table 3-A are self-administered drugs.

Q. So, you were looking for drugs -- sole-source drugs that did not face therapeutic competition and -- basically --

A. I was looking for -- you're mischaracterizing.

Q. Okay.

A. I was looking for sole-source drugs that did not need to use nontransparent spread competition to -- to capture market share. They were the only drug in the category. And that reflected then a relationship between AWP and the

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transactions prices that was not in any way tainted by any kind of alleged fraudulent spread manipulation.

Q. Well, when you say they were the only drug in the category, is that another way of saying they didn't face therapeutic competition?

A. They didn't face -- that's one of the characteristics of it.

Q. So, you were looking for drugs that did not face competition to use as comparators to drugs that did face competition.

A. I was looking for drugs of a certain type that did not require the use of spread to capture market share. So that the relationship between an AWP and an ASP and the transactions prices for which it were a signal was not -- was not going to be affected by the need to try and offer hidden inducements.

Q. So, your comparison would not work if the marketplace was aware that the spreads for drugs that faced competition are larger than the spreads for drugs that do not, correct?

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A. My what wouldn't work?

MR. EDWARDS: I'll have the reporter read the question back.

(Question read back.)

A. No, my -- my approach here works precisely, and my comparator drugs work precisely to get at that. The problem that -- we see a drug like Zofran. When it's not facing any kind of therapeutic competition, it's pricing at yardstick levels, 18 to 22 percent above -- where the signal of AWP is reflecting an understood signal where Mr. Young and a variety of people have talked about what does AWP signal for? You reimburse at AWP less 13 to 18 percent. There's some margin for pharmacies. You look at Zofran. It's right in that sweet spot. It's the only game in town. It doesn't need to offer -- it doesn't need to raise its AWP to attract any kind of regulatory oversight, nor does it need to lower its ASP to reduce its -- its marginal revenue on that unit or reduce its average revenue overall.

So we see spreads for that drug of 18 to

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22 percent. As soon as Kytril came on the market, there's -- in my Attachment F, I -- I present a variety of internal documentation saying we've got to use the spread to compete. We'd better offer the docs this, we've got to do this, we've got to do that. They're doing exactly what has been alleged as soon as there's been that therapeutic competition. So this thing is designed precisely to take into account when therapeutic competition, when the pricing formulation -- when the reimbursement formulae -- formulae are in place and there is therapeutic competition, they're going to abuse this system, and that's the case of Lupron/Zoladex; it's the case of Vincasar; it's the case of Zofran/Kytril. So my spread is precisely aimed at seeing when that kind of competition takes advantage of a reimbursement system.

Q. I want to direct your attention to Paragraph 60-F of your declaration, Page 42 you say, "There is no evidence that the yardsticks for TPP price expectations for multi-source physician-administered drugs were any different than those for

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single-source physician-administered drugs."

Are you aware of any evidence that would support your opinion that third-party payers were not aware of the difference in spreads between drugs that faced competition and drugs that did not?

MR. NOTARGIACOMO: Objection. You can answer the question.

A. Well, what I've said in -- in that paragraph -- in that subparagraph and in the -- and then also referred to Doctor Berndt's opinion on this matter, there was not the -- that the literature in the public domain is -- it's -- his point is not helpful in the area of generic drugs administered by physicians, i.e., multi-source drugs.

Now, what that says is that there -- you know, there's limited information, but that there -- it is from -- my reading of the information that is available, and Doctor Berndt's, apparently, there is insufficient information to draw conclusions about what a spread would be for multi-source. And in an absence of -- of more complete, full information, as

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I look at the way reimbursement contracts are formulated and entered into, the rule of thumb would be the single-source spread -- yardstick.

Q. Didn't Doctor Berndt, in fact, observe that payers are willing to let providers earn additional spreads on generics as a way of encouraging generic use?

A. You'd have to show that testimony to me.

Q. While we're getting that document, why don't you take another look at the Killion deposition. I forget which exhibit it was, but maybe you can tell us?

A. I can. It's Exhibit Hartman 037.

MR. EDWARDS: Well we found the Berndt document. Let's do that one first.

THE WITNESS: Okay.

MR. EDWARDS: We'll mark this as Exhibit Hartman 047. It's Doctor Berndt's report.

(Report of Ernst R. Berndt marked Exhibit Hartman 047.)

Q. I want to direct your attention to Paragraph 52. Doctor Berndt says, "In the context

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of generic drugs, one widely understood reason third-party payers have long been willing to allow pharmacies to enjoy a considerable spread on their generic drugs is that whenever a generic version of a drug is dispensed, instead of its brand version, the third-party payer typically saves a substantial amount of money, recall the earlier discussion on average brand prescription prices being considerably --

A. Sir.

Q. -- considerably less than average generic prescription prices."

A. I'm sorry. Did you say Page 52 or Paragraph 52.

Q. Paragraph 52?

A. I'm sorry. I'm at Page 52 and I wasn't seeing anything you were reading. Okay. So, if we could start again.

Q. In Paragraph 52, Doctor Berndt is saying that "Third-party payers have long been willing to allow pharmacies to enjoy a considerable spread on generic drugs as a way of encouraging their use."

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Isn't that inconsistent with your statement that there is no evidence that yardstick -- yardsticks for TPP price expectations for multi-source drugs was the same as for single-source drugs?

A. No. I mean, in this context, Doctor Berndt is talking about self-administered drugs, and he's talking about pharmacies, and the -- certainly self-administered drugs is a much larger body of drugs than physician-administered drugs, and how the -- what the behavior -- the reason that -- it's my understanding -- that Judge Saris and the court have carved out the classes we're looking at is the differences between self-administered and physician-administered drugs.

So, this tells me about data and understandings and what third parties knew about self-administered drugs, which were -- is a much larger percentage of the total drug bill and so this tells me nothing about what we're talking about with physician-administered.

Q. So, you're saying that payers were aware of spread-based competition for self-administered

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drugs but not for physician-administered drugs?

MR. NOTARGIACOMO: Objection.

A. I'm saying that if one looks at the -- if we had -- I don't cite Doctor Berndt in enough detail, but the -- the type of generic spreads that were revealed for self-administered drugs, you're seeing generic competition there. You're seeing spreads for multi-source physician-administered drugs, but third -- when you look at the -- at the hierarchy of costs faced by managed care organizations, you're looking at hospitals' costs, you're looking for physicians' costs, you're looking at a lot of other costs, and prescription drugs account for 5 to 8 percent over the last decade, but of prescription drugs, the physician-administered drugs are a couple -- are a few percent of that total amount of all those drugs.

So that I'm saying that third-party payers certainly dealt with the issue of self-administered drugs and reimbursements, therefore, to a much greater extent and were much more -- seeing more data informing that than they certainly were for

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physician-administered drugs, given that it was a -- physician-administered drugs is a very small part of what they reimbursed for and --

Q. You were --

A. -- and secondly, the physician-administered drugs were a type of drug where a third-party payer is more loathe to get involved in trying to deal with formularies and trying to get them to do substitution. It's something that's left to the physician.

Q. We're talking about the same payers here, right?

A. We are.

Q. There are payers that --

A. We are.

Q. -- pay for both self-administered drugs and physician-administered drugs, correct?

A. And for hospitals and for doctors and for many other things.

Q. And you're saying that it is your expert opinion that even though a payer may have been aware of spread-based competition for generic drugs on the

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self-administered side, it never would have occurred to that payer that the same sort of competition would take place on the physician-administered side?

MR. NOTARGIACOMO: Objection.

A. I'm saying I'm agreeing with Doctor Berndt. I'm saying that the self-administered would get more focus, more understanding, more -- more strategic response to and decision about than on the physician-administered drugs where Doctor Berndt himself says there's very little information on what this is for physician-administered multi-source drugs, not for generic drugs generally. And it's a different kind of drug where it's -- the -- the substitution from a -- from a branded to a generic and the bioequivalency thereof in pharmacies and based on formularies with PBMs is driven by a whole different set of circumstances than what a doctor decides to do in what its administering and whether a third-party payer is going to sit back and -- and leave that decision and be -- and focus on what can be accomplished through -- through multi-source competition.

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Q. Can you cite me any evidence that would support your opinion that payers were not aware of spread-based competition for multi-source drugs on the physician-administered side?
A. We've -- we've already said that there's -- there's been limited information that has appeared throughout this period of time from mid '90s to recently, and to the extent that it has affected an understanding of -- of what the relationship should be, the -- there is no consistent information that I see that will -- that would suggest to me that, as a rule of thumb, the 30 percent should be altered.
Q. I asked you for evidence, citations, depositions.
A. You're asking me for evidence to the contrary. I haven't seen any.
Q. Documents.
A. So if there's some that I should see you should -- you should show them to me.
Q. Well, if I were to show you evidence that payers were aware of spread-based competition for multi-source drugs on the physician-administered

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side, would that affect your opinion?
A. I would need to see sufficient information that this was understood and institutionally, so that it wasn't just anecdotal information or one -- or one deponent who says, oh, if the spread happened to be this or, yeah, I think it's this or that, I'd need to see a much more well-informed and scientifically-designed survey, and I'd need to see some revealed -- real -- revealed behavior in those regards before I would -- but if -- and if that exhibit -- evidence exists, I would like to review it.
Q. Evidence that it was common knowledge would be of interest to you, correct?
A. Evidence that the reimbursements should change as a result of the fact that -- that the -- the patterns that have been put in place should be altered to eliminate the amounts of money that were being made, that that should be changed, that would be of interest to me.
Q. So, evidence that it was common knowledge would not have an impact on your opinion?

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A. Well, I don't know what -- I'd need to know -- I'd -- if you -- if there are surveys of what the knowledge is and -- and the numbers of insured lives and the percentages of insured lives and whether that was being evaluated as to how to -- to alter reimbursement rates, that would be -- that would be informative.
Q. Let's take a look at Mr. Killion's deposition, which is Exhibit Hartman 036. And as you may recall, Mr. Killion is with Blue Cross Blue Shield of Massachusetts, one of the class representatives here. I want to direct your attention to Page 122 of the deposition. Do you have that in front of you?
A. I don't yet. If you'd give me a second, I will have it shortly. I'm sorry. What page were you saying?
Q. 122.
A. 122. Okay.
Q. "Question: Was it also your understanding at the time that when competition came into the market for brand name drugs, i.e., multi-source

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competition, there were also discounts and rebates that were provided on those drugs? Answer: That's correct. Question: So, typically -- so it was your understanding then in the 1998 time frame that when a brand name drug first came to market, there typically were no incentives associated with the drug but then as competition entered the market, first multi-source and then with generics, more incentives were provided for the drug, correct? Answer: Correct. Question: And that is what led to your understanding that AWP was an artificial price because it didn't bear a relationship to the acquisition cost, correct? Answer: Correct."
Now, does that have any impact on your opinion that TPPs, third-party payers, did not believe that there was any difference in the spreads of multi-source drugs versus single-source drugs?
A. No. This -- this fits within the -- the contours of just what we've been talking about of more people becoming -- understanding the extent to which there were these kinds of deviations. And where there was competition on spread, and that they

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were unaware of but that they became aware of and that led to -- to -- that kind of information needed to be institutionalized in a response, and just knowing of some of this doesn't say that -- that the -- a given institution was able to rearrange its reimbursement policy to avoid being over-charged by the reimbursement rate -- reimbursement policies that were put into place 12 years later.

Now, you've also -- we've also seen some documents where people started making institutional decisions about -- saying, oh, God, this is happening, and that's where you start to see preferences being revealed. Right here I'm just seeing, again, the understanding that they're -- look, there's -- there's either with certain branded drugs, there's -- there's spread competition that leads to reimbursement rates that are -- are higher than acquisition costs than what we had thought they were. And this is the same thing with the -- with the generic. But it has yet to be institutionally responded to where they've revealed this -- this -- in the response to their change in reimbursement

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formula.

Q. Well, it may have been institutionally responded to through MAC pricing, correct?

A. If -- if they -- if they -- if they switch to MAC pricing on -- and they were pushed -- and they pushed them to MAC pricing, that is one way that there was a response, and my model has taken that into account, that as soon as there are the multi-source in a nonMedicare setting, as soon as there are multiple generics, I dropped them from any analysis because the MAC pricing -- because under the -- I think that's under the guidance of the judge, saying that under MAC pricing there's an assumption that it's not formally related to AWP.

So, yeah, I mean, when there's MAC pricing, I dropped them out of any kind of finding of -- or calculation of damages.

Q. Well, you dropped them out of any calculation where there could have been MAC pricing. You don't conduct any investigation to determine whether the payer actually engaged in MAC pricing, correct?

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A. The -- I make the assumption that -- let me just make sure I don't misspeak. (Witness reviews documents.) Sorry. This is taking this amount of time. So put this here.

Okay. For -- in Paragraph 63 and 64 where I talk about calculating damages in Paragraph B of 63, I use my 30 percent spread when single -- and allow that single-source drugs remain subject to damages, and that when there's multiple -- when there's multi -- multiple generics launch, unless I have information to the contrary, I assume that it's multiple generics; and that I assume MAC pricing is introduced and damages that are calculated are essentially set to zero. They're not calculated. I assume they don't reference AWP. So they -- so the spreads may be greater than that, but once there's multi-source, I dropped them from any kind of measure of damages.

Q. By assuming that MAC pricing could have been introduced, you're basically saying that the revealed preference of payers in that circumstance would either be the implementation of MAC pricing or

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a decision to permit providers to earn whatever profit they're earning on the spreads for generic drugs, correct?

A. When third-party payers saw the types of prices that were being paid in the market for generics, that -- MAC pricing was a response to that, and that was a revealed contractual response as to that -- to that phenomenon.

Q. I want to go back to the Killion deposition, Paragraph 36 -- I'm sorry. Exhibit Hartman 036, Page 126.

A. And, I'm sorry, which page? 1 -- the Killion deposition, which -- did you give me a page or not?

MR. NOTARGIACOMO: 126.

Q. 126.

A. 126.

Q. Beginning at Line 9. "Question: Was it your understanding at the time that it was basically common knowledge that acquisition costs varied depending on whether a drug was brand or multi-source or generic, given the level of competition in

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the marketplace for the drugs? Answer: Yes."
A. Okay. Can I --
Q. Does that affect your opinion that there's no evidence that payers expected that the spreads for generics and multi-source would be any different than the spreads for single source?
A. I'm -- I'm looking back to see the context of whether this is self-administered, whether this is all drugs, whether this is focused on physician-administered per se. (Witness reviews document.) So, so far I'm seeing that these are all self-administered drugs that they're talking about. I'm seeing pharmacies and the use of PBMs and all of which did affect MAC pricing and was more aggressive for the self-administered drugs.
So, I'm seeing your -- the citations that you're -- the quotes that you're getting at are really not even directed to our group of drugs since PBMs generally are uninvolved with -- with physician-administered drugs and the pharmacies are generally uninvolved with physician-administered drugs.

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So, I don't know what this tells me about what -- some knowledge about self-administered drugs, because, as I said, that's a much different kettle of fish than has been recognized by this court and recognized generally by students of the -- of the industry.
Q. Well, the witness in that answer doesn't distinguish between self-administered drugs and physician-administered drugs, does he?
A. Well, if you go back, I mean, that's why I went back to -- to the preceding pages, and I went back to Page 120 and he -- they're talking about -- you had discussions with other individuals at Tufts at that time regarding the fact that AWP was artificial. And then the answer -- "we had concerns with regards to AWP as the price in which we reimbursed for drugs at the retail pharmacy and encouraged our physicians to utilize generics."
Now I see that as pharmacy-related stimuli to physicians to move drugs, and then the mention of the PBMs is on Page 125, and all of this is in the context of PBMs and pharmacy decisions, and I -- so

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I -- I don't see where this -- I mean, it -- you may be able to contextually relate it prior to Page 121. And this set of Q&A as I see it just focused on self-administered.
Q. So, are you now changing your testimony and saying that a self-administered drug would not be a good comparator for a physician-administered drug?
A. No.
MR. NOTARGIACOMO: Objection.
A. I looked at self-administered drugs of innovator drugs, single source unique drugs. We're talking about generic competition in self-administered drugs. That's not -- that's orthogonal to my opinions that I've put forward.
Q. Would you agree with me that after the introduction of generic drugs the prices of generic drugs follow a predictable trajectory from the pre-generic launch brand name price toward variable production cost as more generics come into the market?
A. That sounds like a -- like a -- a very-

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well crafted sentence.
Q. So you would agree with that sentence.
A. I would. But I would -- I would qualify it for self-administered drugs. There's not much evidence available for physician-administered drugs that I am aware of or that Doctor Berndt is aware of to make characterizations that I would -- that I -- for which I agree with that.
Q. Certainly payers who purchase drugs directly from manufacturers would be knowledgeable about spread-based competition, depending on the extent to which there are alternatives for a particular drug. Would you agree?
A. And are we -- to try and give specificity to this, are we talking to -- about staff model HMOs, something like Kaiser, or is that what you're asking about, someone like Kaiser?
Q. Sure.
A. Yes. They would -- they would have more information, and I would point out that we've excluded -- I've excluded those sales to those entities from the damage analysis.

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Q. Well, those entities are also third-party payers, correct?
A. They're third -- a Kaiser is both -- deals with insurance and deals with the administration of the drug, and they were not considered part of the class as being indirect -- indirect payers and the -- as I have -- when -- when we were doing the analysis of the units that were subject to damages, sales to those types of entities, I asked my staff to exclude, and they did the best they could given the interpretation of the customer names and the classes of trade codes that were found in Defendant's data.
Q. So, let me make sure I understand what you're saying. You understand that many third-party payers also own their own HMOs, correct?
A. I know that -- that some third-party payers are affiliated with H -- with -- do you mean PBMs or what --
Q. No. I'm talking about HMOs or hospitals.
A. The precise affil -- set of affiliations between payers and how many are integrated with

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hospital, I have not done sufficient analysis of to really comment on.
Q. Well, a payer that owns an HMO or a hospital and purchases drugs directly from a manufacturer would know about spread-based competition, correct?
A. A third-party payer that -- one of whose subsidiaries buys drugs directly hopefully should be informed by those subsidiaries to the --
Q. Okay. So, in the case of Kaiser Permanente or other payers like that, you're not simply excluding the sales to the HMO from your damage calculation. You're excluding all reimbursements made by that payer, correct?
A. What I have done in my declaration and asked my staff to implement in the damage calculation is to identify those sales -- unit sales -- to clinics, to oncology groups, to GPOs that are unaffiliated with payers, that are essentially providers.
Q. So --
A. That are -- that are then going to submit

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the reimburse -- claims for reimbursement to third-party payers.
Q. So, you only exclude from your damage calculation then the sales to the provider operation of that payer. You don't exclude all reimbursements by that payer, correct?
A. I'm not quite sure I understand. If -- if a given -- if -- say Kaiser is one example. We exclude all sales to Kaiser and we exclude all sales to any hospital, even though we know some of them will be subject to reimbursement by third-party payers in an outpatient context. It -- precisely to avoid some issues of -- to be conservative.
Q. Well, let's take Blue Cross Blue Shield of Massachusetts. Did you understand that for a period of time Blue Cross Blue Shield of Massachusetts owned an HMO?
A. I know there was an issue. It is my recollection that there was an issue about -- about that and which years it -- that was relevant, but I forget the details at the moment.
Q. So, assuming your staff carried out your

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instructions properly and they had adequate information, they should have excluded from the damage calculation the sales to that HMO, correct?
A. If there were sales to what we've classified and -- and I asked the staff to -- as -- as staff model HMOs like a Kaiser, they attempted to do so as best they could with the -- with the names that -- the data that was given to us.
Q. And the reason you excluded those sales is because, as a direct purchaser from a manufacturer, that HMO would know about the spreads. In fact, that HMO would be one of the entities out there getting the discounts that create the spreads, correct?
A. The -- the guiding decision, and I'm looking back here at the class definition, was to focus, in my recollection, it's not stated here specifically, on indirect payers. And so by definition, a Kaiser is a direct purchaser and -- in a staff model HMO. I think correct.
Now, I don't see that as being stated here within this Subclass. And so I should perhaps go

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back and look at the earlier complaint to see whether my understanding is consistent with that.
Q. Isn't it inconsistent to exclude the sales to the HMO but include all of the reimbursements by the same company? In other words, let's take Blue Cross Blue Shield of Massachusetts. Let's take a particular drug. My client, BMS, Vepesid, and let's assume that BMS sold a million dollars worth of Vepesid to the Blue Cross Blue Shield of Massachusetts HMO and Blue Cross Blue Shield of Massachusetts also reimbursed providers for $100 million in sales of Vepesid. You would exclude the million dollars paid by the HMO from your calculation, but you would include the $100 million paid as a third-party payer in your damage calculation, correct?
MR. NOTARGIACOMO: Objection.
A. I would -- in situations of that sort -- you've -- you've identified one more type of payer that has some information -- maybe it's more, maybe it's less than what's -- what appears in Medicare, but the fact that it its reimbursement schedules are

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based on revealed negotiations from an earlier period of time and a revealed understanding of what the relationship between AWP and transactions costs were, and there is some information here that that's to Blue Cross Blue Shield of Massachusetts but that they haven't acted on it, it means that institutionally they have yet to assimilate that and -- and be able to have moved to insulate themselves from the -- the abuse alleged in the matter.
Q. Let's take some additional examples of this.
MR. EDWARDS: What I want to do is mark as Exhibit Hartman 048 an excerpt from the BMS charge-back database for Customer Code 26.
(Excerpt marked Exhibit Hartman 048.)
Q. Did you exclude sales to Customer Code 26 from your damage calculation?
A. This is for BMS?
Q. Right.
A. (Witness reviews document.) Yes, I did.
Q. And Customer Code 26 would include CIGNA, HIP of greater New York --

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A. Well it's CIGNA pharmacies in Los Alamitos, California. It's -- in Arizona and Florida. Are you saying CIGNA overall or.
Q. Well three of the CIGNA plans.
A. Okay, right.
Q. Right?
A. Right.
Q. Lots of HIP --
A. Right.
Q. -- entities. Do you want to go through them all?
A. No. No. No. I'm --
Q. Okay.
A. The --
Q. And indeed you've got HMO Blue at GMA, correct?
A. Hey.
Q. And Humana?
A. We made it. God. We're right there with --
Q. And Kaiser?
A. Right. Can I keep this?

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Q. Sure.
A. No, I'm just kidding.
Q. You exclude direct sales to all of these entities from your damage calculation, but you don't exclude these entities from the third-party payer class, correct?
A. We exclude certainly the direct sales and then the charge-back related data, but that is true to the extent that there are indirect reimbursements to these entities, they are included.
Q. You include them in the class, even though they were obviously knowledgeable about the spreads?
MR. NOTARGIACOMO: Objection.
A. Well, it --
MR. NOTARGIACOMO: You can answer the question.
A. There's -- they purchased these drugs and to the extent -- I can't -- until I see that they have either responded to it with the contract change, such as MAC, or they've responded to it institutionally and said we're going to just ignore this, I have no information that whatever kind of --

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that this particular line item of costs that are borne that were -- whoever's paying for these drugs and then using them in their staff model context, whether that is fully communicated and made clear to the -- to those that are reimbursing other providers, that they have -- there's no evidence that they have been able to institutionally make a decision of how to avoid the excess spreads.

Q. You're not saying that these guides are stupid, are you?

MR. NOTARGIACOMO: Objection.

A. No.

Q. Take a look at Page 8 of your declaration, Paragraph 13.

A. Okay. You will.

Q. You'll see there's some quoted language there where you're quoting Judge Saris stating that, "There is no evidence that TPPs purchased physician-administered drugs." With all due respect, would you agree with me that that statement is not correct? There is evidence that TPPs purchased physician-administered drugs -- we just looked at

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it.

A. Do we have a copy of the memorandum and opinion?

Q. I don't believe I have one with me.

A. Okay. I wanted to see whether indeed that was an order there. The -- you've shown me, you know, evidence for this customer code on the part of BMS. The -- you know, my -- my understanding of the judge's statement here is that the -- that third-party -- that there's no evidence that third-party payers purchased physician-administered drugs in a sufficient amount to make this of matter to them or to make the knowledge of the megaspreads reach a sufficient level for them to alter reimbursement practices put in process to avoid the overcharges that exist.

Q. Do you know the dollar value of the drugs that Kaiser Permanente purchases from these Defendants every year?

A. Yeah, and I would assume that the amount of -- of drugs that Kaiser Permanente reimburses for that are from other providers is -- is much smaller

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than that. And so, they are -- they're doing -- they're focusing on what they purchase and use in their own context, and that's -- that's going to be the primary focus of their -- of certainly their cost analyses for physician-administered drugs within that institution.

Q. Well, let's -- let's see if we can get a definitive answer here. Would you agree with me that there is evidence that TPPs purchased physician-administered drugs?

A. You have -- you have --

Q. Can you answer that question yes or no?

MR. NOTARGIACOMO: Objection.

A. Well, I want to -- I want to -- you've handed me some documentation from which you've asked me to draw a conclusion, and I want to make sure I fully understand it. You know, it's -- I'm not going to answer a question that I don't understand. I will agree that there are third-party payers who have a division of -- who have a -- a staff model-like division which purchases physician-administered drugs.

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Q. And Judge Saris goes on to say, "There is no evidence that TPPs know of the megaspreads that exist with these drugs." There's evidence of that as well, correct?

MR. NOTARGIACOMO: Objection.

A. Not in an institutional way that they've acted upon it or made -- or revealed attempts to act upon it or -- period.

Q. Would you -- strike that. Have you considered whether there are ways that third-party payers can protect themselves even if they have no knowledge of the spreads?

A. Ways that they could protect -- they -- so what you're asking me is they're being gouged, let's say, or they're paying --

Q. Well you're assuming the conclusion. I'm asking you to back up before you reach a conclusion.

A. Oh, I'm sorry, could we have the question reread?

Q. And what I'm asking you is whether you considered whether there are ways that TPPs, third-party payers, could protect themselves, even if they

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didn't know what the spreads were?
A. Well, how can I consider that without starting with the premise they're being -- they're being gouged but don't know it. Sounds like you're saying are there ways -- they're not -- they're -- they don't know that they're being overcharged, isn't that -- that's the premise. Are there ways to protect themselves, even though this is going on and they don't know it? Is that -- is that the question?
Q. Are -- are you aware of the economic literature which demonstrates that a buyer can enter into a transaction at a competitive price, even if the buyer doesn't know the seller's costs because the buyer is protected by competitive forces?
A. So, the question is you have a competitive market that's operating competitively. Competition really works and all that that implies in terms of information and knowledge and what's built into the assumptions therefor and someone walks into that market and buys at the market-clearing price.
Q. No. Every buyer has to be knowledgeable

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if they're in a competitive market, correct?
A. It's --
Q. I mean there's a lot of economic literature about that, isn't there?
A. You need to -- you'd need -- once you start drawing gray lines, it's going to have to be how much, how large, what kind of effect does that have? I mean it's -- the paradigm you're talking about, a competitive market has -- raises certain assumptions. Now, in -- a noncompetitive or a partial -- or imperfectly competitive market -- I'm hearing you talking about a perfectly competitive market. Are you talking about an imperfectly competitive market? I mean there is imperfect competition and that has certain implications.
Q. Isn't that exactly what Doctor Berndt concluded with respect to self-administered drugs? Didn't he conclude that there either was no fraud or no harm from any fraud with respect to self-administered drugs because competitive forces would have dissipated any of those effects?
A. With respect to physician-administered

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drugs?
Q. I said self-administered drugs.
A. Oh, self-administered drugs. Doctor Berndt -- I'd have to go back and -- why don't you show me the sections where -- where -- to which you're referring to.
Q. You don't have any recollection --
A. I remember --
Q. -- of him reaching that conclusion?
A. I remember him discussing competition. I remember him discussing the -- the bid process with -- with PBMs and the -- and the results of that type of competition. I also seem to recall -- well, let me pull him up.
Q. I know, I want to move on if that's okay with you?
A. Okay. I would say that he did not put forward -- he certainly talked about competition. He also talked about the fact that competition among PBMs allowed for a -- some protection from the spread, but he also said that, you know, that there -- that certainly not all of the -- it's my

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recollection that he -- that he said not all of the -- that the consumers weren't protected entirely; that -- that payers were willing to give up -- that they -- if -- if the discounts on generic drugs were 80 percent and third-party payers got a 30 percent discount, they were happy with that. So, there was a -- it certainly was conditioned, as opposed to saying that they're fully protected.
So that your -- your characterization of it is that third-party payers are protected in a self-administered context is a -- is a very limited one. It's the -- the effect of spread competition is -- the full impact of it is diminished to a certain extent, but not eliminated I would -- is how I would characterize it.
Q. Have you attempted to analyze the extent to which competition has dissipated any of the effects of the alleged deception that you say exists with respect to physician-administered drugs?
A. I haven't had the -- the data nor I -- I haven't been asked to do that, no.
MR. EDWARDS: I want to mark as Exhibit

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Hartman 049 a copy of the deposition of Mike Beaderstadt. Actually, I think this was previously marked but let's go ahead and mark it again 'cause it will be quicker.

(Beaderstadt Deposition Transcript marked Exhibit Hartman 049.)

Q. I want to direct your attention to Page 75, beginning at Line 22.

A. I'm sorry. Before I go to any -- I want to just see who this -- who Michael is? (Witness reviews document.) Okay. And I'm sorry. So, go ahead.

Q. Beginning at Line 22, question --

A. But of which page? I'm sorry.

Q. 75.

A. Line -- Page 75.

Q. "Question: In your experience at John Deere, have you ever doubted AWP as an accurate source for reimbursement? Answer: We have never used AWP in the pharmaceutical world as a source for reimbursement. We used it as a source to calculate our reimbursement. Question: Correct. Have you

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ever doubted AWP as a basis or benchmark for reimbursement in the pharmacy world? Answer: My perspective is that we always try to get that price as low as possible that still puts together a reasonable network, and we'd go to minus 25 percent and nobody would sign it, and we'd try minus 13 percent and everybody signed up, so we knew we had to have it somewhere in between there. And minus 20 is our latest venture there. And that has produced some headaches for us, but we have been able to put together a reasonable network based on that. So, again, it's simply a basis for negotiation and we try to do as well as we can to lower our costs for acquiring those drugs."

Have you considered whether that process that Mr. Beaderstadt describes takes place in the physician-administered side of the business?

A. I've seen -- I've seen a lot of testimony of this sort, which certainly does demonstrate that AWP is a yard -- is a benchmark measure for pricing and for -- for reimbursement and also indicates that there's a -- the -- how negotiations try to lead to

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some reimbursement rate that's going to be somewhat above cost.

I haven't seen this type of testimony with respect to physician-administered drugs.

Q. This was testimony elicited by Plaintiffs' counsel in this case, is that correct?

A. I -- I wouldn't know. I assume you would be able to tell me better than I'm able to tell me.

MR. EDWARDS: What I want to do is mark as Exhibit Hartman 050 a copy of the deposition of Christopher Eddy, held on October 6th, 2004.

(Deposition Transcript of Christopher Eddy marked Exhibit Hartman 050.)

Q. Mr. Eddy is from Empire, Empire Blue Cross.

A. Okay.

Q. That's the Blue Cross company in New York or it was the Blue Cross company in New York.

A. Right.

Q. It has now been acquired by Anthem Wellpoint. I want to direct your attention to Page 74, Line 19. "Question: How do you decide whether

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to accept an offer of a different fee schedule from a provider? Answer: Specifically when a doctor puts something to us in writing, we review the request and we look if there is a network need for the provider or if that provider left our network would we have providers that still maintain our patients, see our patients, and in some areas, they are the only providers available. So, we need to keep them in our network. So we look at their -- at their proposal and we work with them and try to come up with something mutually-agreeable to both parties and that is presented to my boss with the information to get approval for that.

"Question: How do you decide if it's agreeable to Empire? Answer: That would be actually once I spoke to the group and we've mutually agreed to something, I would have to present that to my boss to see if that is something that the company would agree upon with the data that I have available and discussion with the doctor's office and the reasonings why we had to negotiate. They look at a lot of different variables and as for

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their decision, they may come back and ask more questions. They make the final decision on what I am presenting to them. Question: What factors do you consider? Answer: I consider -- the biggest factor I consider to me when I negotiate with a group is the member -- is if I don't have this doctor, what's going to happen to my patients and their satisfaction with the network, and that's my biggest consideration I look to do a negotiation."

Now, does that suggest to you that the same kind of economic forces that Mr. Beaderstadt was describing in his deposition also apply to the physician-administered side of the business?

A. Well, on the physician-administered side of the business you're going to have payers approaching providers and there's -- there's going to be a -- a set of -- of issues that will enter into and inform that negotiation and the -- the MedPac report gets into what some of those different things are. The University of Chicago in the NORC report on the -- for the various stakeholders of -- of how those -- that negotiation occurs, and there's

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a -- there's a number of things that enter into that negotiation, and clearly patient satisfaction is one, and we have -- we have data on revealed results from those negotiations in those two studies in that we find reimbursement -- negotiated reimbursement rates of AWP plus or minus 15 percent or so.

So, this says to me that if you've got a doctor that's a -- really a hot ticket out there, that doctor may be -- we find reimbursement rates of AWP plus 10.5 percent, they might be able to negotiate a higher rate. You find some with less negotiating power. It may be AWP less 12 percent. There's a number of things go into the negotiation.

I would say that negotiations occur. I wouldn't necessarily characterize it as the same size of the -- the amounts of money involved, the same number of competitors, the same number of players. In the self administered drugs you've got national PBMs. When you're a provider you're looking at local doctors with more market power. But in either of those cases, negotiations go on; payers come in with a -- with an offer sheet of ranges of

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things that they're going to agree to or that they're willing to trade on, and we see the results of that in the physician-administered drugs that are part of my yardsticks.

Q. Isn't the kind of thing we're talking about here where a payer can negotiate a competitive price, even if they have no knowledge of spreads, simply Economics 101?

A. No.

MR. EDWARDS: Let's take a look at Mr. Morris' deposition which we'll mark as Exhibit Hartman 051.

(Deposition Transcript of David Morris marked Exhibit Hartman 051.)

MR. NOTARGIACOMO: When do we plan on taking a break for lunch? It's 1 o'clock. We've been going over an hour and a half.

THE WITNESS: They're not going to let me take lunch. They're going to chain me to this chair.

MR. EDWARDS: I just have something quick on this document and then we can break. My voice is

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also giving out.

Q. Mr. Morris is from Anthem. I want to direct your attention to Page 68 of his deposition.

A. Okay. Just --

Q. Beginning at Line 12.

A. I'm sorry. Before I'm going to look at anything I'm just going to look a bit at his position in Anthem. I just -- (Witness reviews document.) Okay. So now, which page?

Q. 68.

A. 6 --

Q. Beginning at Line 12.

A. 68. Okay.

Q. "Question: To what extent did Anthem analyze the cost to a pharmacist compared to the total reimbursement amount being given to a pharmacist in terms of for a particular product? Answer: Are you asking, you know, did we look to try and determine what their profit margins were based on our network reimbursement? Question: Yes. Answer: We did not ever do any type of analysis. Question: Why not? Answer: Probably because we

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didn't want to. I mean, we had no access to -- ready access to wholesale acquisition costs or individual pharmacy agreements with wholesalers or suppliers and so, it would have been impossible for us to really accurately have estimated what a pharmacy was paying for its product. You know, at the point you stop having pharmacies participate in your network you know you've gone too far, and we were nowhere close to that in my opinion. So they were still making money at AWP minus 15 or AWP minus 16.

"Question: So, would I be correct that the way that you determined what your reimbursement rates would be was not so much based upon what their actual acquisition costs were but based on how you saw pharmacists reacting to the reimbursement rates you put out there? Answer: What the market -- what will the market bear, yes, I mean it's all Economics 101. At the point they stop or scream too loudly, you know you've gone too far. They tie their reimbursement drugs to things other than cognitive services and counseling, and that's a whole separate

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topic but" -- we won't go into that topic but my question to you, sir, is whether you agree with Mr. Morris' statement here?

A. Well, I think this is really a topic for Economics 1, not 101, but that -- putting that aside, you know, what -- he's talking here about physician -- about self-administered drugs. He's talking about pharmacies. He's talking about a situation where the negotiations are subject, on both sides of the negotiation, to countervailing market power with PBMs, with large retailers and the -- what he's saying here is that, again, AWP is a benchmark. They're negotiating at reimbursement rates for -- and I'm seeing this -- AWP minus 15 or 16. That used to characterize everything until it became clear that generics were -- self-administered generics were on the market, and then there was a revealed change toward MAC and they were able to protect themselves on spreads there that would differ from these -- these spreads, and this is -- this is for self-administered drugs, and that's subject to -- it is -- it is more subject to a

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workable market than the physician-administered drugs are, but you know, you're talking about negotiations here and this certainly wouldn't -- doesn't protect them from -- from spreads on multi-source drugs, AWP minus 15 or 16.

So, this is a very -- very specific quote you've brought up for a very specific issue, but it -- it doesn't have general relevance to the -- to every aspect of the market in physician-administered drugs in all negotiations in every context.

Q. Can you cite me any evidence that would support the proposition that the negotiation dynamics that apply to provider negotiations on the physician-administered side differ from the negotiation dynamics that would apply to negotiations with pharmacies on the self-administered side?

A. I am a large payer and I'm negotiating for -- with PBMs and they're large national PBMs and you know, there could be five to seven dominant ones and a variety of other ones, and I can get RFPs from a lot of PBMs for different types of reimbursement

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schedules, different types of MAC; I can ask for -- for those RFPs. That's -- that's the dynamic we're talking about with self-administered. I'm now a doctor -- I'm not a third-party payer that's thinking of my provider network, and I'm thinking about an oncologist or an oncology group in upstate New York. There are very few oncology groups in upstate New York. There's market power by these specialists that provide these kinds of drugs. They are able to negotiate much more aggressively vis-a-vis -- or refuse to accept certain positions, vis-a-vis a payer. They have market power. They are one of the few games in town.

Q. I asked for evidence. Do you have evidence?

A. Well, are you telling me that that's not - - that's not factually correct? That's a summary of my -- my knowledge of -- of the -- of what the self-administered side of the market looks like and the physician-administered side when negotiations take place.

Q. Are -- are you telling me that the

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principle of negotiating a transaction that is what the market will bear does not apply on the physician-administered side?

MR. NOTARGIACOMO: Objection.

A. No, you're -- you're totally mischaracter -- I'm saying the market differs, so what the market will bear will differ. The negotiations will take place, and whatever the market will bear will be what the market will bear. But the market structure and performance and dynamics are much different when payers are negotiating with national PBMs and what they can negotiate. That market will lead to something different than a market negotiating with local oncology groups or local specialists.

Q. But payers do have the ability to determine what the market will bear on the physician-administered side, correct?

A. And MedPac has shown the -- and has shown the results of what -- what those negotiations have led to.

MR. EDWARDS: Okay. Why don't we break for lunch.

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VIDEO OPERATOR: The time is 1:10. This is the end of Cassette 2. We are off the record.

(Whereupon the deposition recessed at 1:10 p.m.)

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AFTERNOON SESSION (1:59 p.m.)

VIDEO OPERATOR: The time is 1:59 p.m. This is the beginning of Cassette No. 3 in the deposition of Raymond Hartman. We are on the record.

Q. Doctor Hartman, I'd like you to turn to the charts that appear after Page 19 of your report. I believe it's Figure 1-A, 1-B, and 1-C.

A. I have done so.

Q. Can you explain these figures?

A. Well, what I was doing here is indicating that among payers we do find variation in reimbursement, summarized by the spreads that I have -- that have been revealed in contract negotiations and reimbursements paid. And that looking at those spreads, looking at that variation, looking at that that -- around there -- in Figure 1-B would show reimbursement rates related to an AWP that is artificially inflated when the actual ASP is much lower. And what I have shown there is that if one were -- if the negotiations had been relative to a

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benchmark price that was an appropriate signal for the ASP that was within the yardstick spread of the ASP, which is the AWP but for, that the reimbursement rates would have been negotiated; that there still would have been the ability to extract different percentages off of AWP by large oncology groups or particular providers that were very important to a payer, but that distribution would be around a lower AWP, and the variation that one observes in reimbursement rates is relatively small or quite small compared to the extent of the alleged -- or the size of the actual spreads that we observed in the -- in the data.

Q. Are there any particular characteristics that you attribute to payers at one end of the curve as opposed to payers at the other end of the curve?

A. Well, I point out in Footnote 11 that Doctor Gaier and Mr. Young and I and I think any student of the industry understands that the size of -- of a particular insurer will allow those payers to -- if I'm -- if I'm a large payer and I bring a lot of persons to a particular provider, that that

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will enter into my ability to be able to have bargaining strength on my side; that the -- what we talked about before about the specialties and a particular doctor that has monopoly power or market power in terms of delivering patients would -- would be -- would affect that kind of negotiation. So, those are two of -- two of the things that would affect that -- that variation.

Q. Are you saying that payers at the top end of the curve -- payers who pay AWP plus 15 percent -- would be smaller payers who are not knowledgeable?

A. I'm saying that there are a variety of -- of factors that will affect this distribution, and the size of the payer will be one thing. So that a large payer may use that position to negotiate aggressively and say, look, if you join -- if I'm -- if I'm -- if I'm going to be a payer for you or if you're going to be submitting your reimbursement claims to me, I'm going to -- I want you -- I want to reimburse you at AWP less 10 percent, 12 percent.

So, largeness could be something that would lead toward a -- a payer being on the left-

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hand side of that distribution. There might be certain aspects of a payer that -- that they decide that they want to offer somewhat more around that AWP, and it -- a large payer might be on the -- on the other end of the distribution. This is -- this is -- this is a distribution that's affected by a variety of things. As I said, this is a negotiation that both -- it reflects what the payer -- the payer's bargaining strength and their preferences and the provider, and it's going to be a mix of things that will determine where on that distribution that that -- that that reimbursement rate will fall.

Q. When you say a large payer may want to offer somewhat more around that AWP, what do you mean?

A. If -- if I'm a payer and you were talking about how does -- how is there negotiations and where is there negotiating strength, and suppose there's an oncology group in New York City that is -- that is world class and -- and I would like to be -- for that -- for that oncology group, I would like

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to be supporting that oncology group and have -- have the patients -- have that oncology group be part of my system, that -- that payer may say, well, look, we will -- in respect -- in response to that position, we will -- we'll reimburse you at AWP rather than AWP less 15, or we'll reimburse you at AWP plus 5. And so, that's what that means.

Q. That oncology group is able to use its market power to induce the payer to pay a certain price for drugs, correct?

A. In these negotiations, the negotiated discount off of AWP reflects the -- the negotiating strengths and positions taken by both sets of negotiators, the payers and the providers.

Q. And that negotiated discount ultimately gets translated into dollars that the provider receives, correct?

A. That's correct. That's right.

Q. And let's assume that you've got a very attractive, unique oncology group that is able to persuade payers to pay it X dollars in the actual world, okay?

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A. Are we talking about --

Q. If you --

A. -- X dollars relative to an AWP? I'm not --

Q. Well that the AWP -- the reimbursement rate translates into X dollars. We can put a dollar figure on it. We can say $10 million.

A. I didn't know whether you were saying they're offering an up-front payment of $100,000.

Q. No. What I'm --

A. You're talking about per claim there's a dollar amount associated.

Q. What I'm saying is let's say you've got a relationship between Payer A and Oncology Group B, and Oncology Group B is an attractive, unique oncology group.

A. Uh-huh.

Q. And I want you to assume that on an annual basis Payer A pays Oncology Group B X dollars --

A. Uh-huh.

Q. -- as reimbursement for drugs, okay.

A. Okay. This is the total reimbursement

1050

amount --
Q. Right.
A. -- that they're paying, okay.
Q. It can be a million. It can be 10 million.
A. Right. Okay.
Q. We'll call it X.
A. Okay.
Q. Okay.
A. Uh-huh.
Q. What is your basis for assuming that that payer would pay that oncology group or that oncology group would accept anything less than X dollars in the but-for world?
A. The reason that --
Q. I mean, don't you think it's likely that the oncology group is going to say hey --
MR. NOTARGIACOMO: I'm going to object. He's in the middle of answering your question.
Q. -- I got X dollars from you last year. I want X dollars this year or I'm taking a hike.
MR. NOTARGIACOMO: I'm going to ask you

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let the witness answer the question you asked.
A. I'm now -- could we have -- could I have the first question read back to me, please.
(Question read back.)
A. Well, what we know in the real world is and what we've seen in the evidence is that the provider -- there's asymmetric information. The provider knows how much they can make with a spread. The payer doesn't realize and hasn't realized that the spreads are as in excess of the -- of the yardstick. And so, right now the -- the providers are able to take advantage of that asymmetric information and their market power and be able to get that X -- that X dollars from the -- from the payers. If the payers understood the extent to which those spreads exceeded what they'd -- what their expectations were and what they'd contracted for and they -- I mean, what we're finding in the -- in the discovery materials and in the MedPac report is that when -- when it becomes clear the extent of the returns to practice, the various -- the participants in the market say hey, wait a minute.

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We're not going to pay that. So the doctors can no longer get away with that because the -- the providers are -- the payers are digging in and saying we're not going to offer that.
Q. Where does it say that in the MedPac report?
A. Actually, it says it in the -- in the sections that I've quoted. The -- in Paragraph 53 I cite two examples that -- well, I -- there's a -- several examples in there, but it essentially cites what the abuses were that were found relative to these drugs and what the response was once there was a -- a sufficient enough understanding of the extent of that spread, and you see a response on the part of regulators and on the part -- on the part of the market. And as you have in the case of TAP, you found that payers -- if one looks at the litigation history in the sentencing memorandum, there were attempts by payers to -- not to pay the amount of the return to practice, and there were -- there was certain information that was -- that was explicitly designed to be hidden from the payers so that they -

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- TAP informed the providers, through their various memoranda, and as the payers learned about it, there was more of a resistance to pay that.
Q. Where does it say in the MedPac report in words or substance that a provider would take less than X in the but-for world?
MR. NOTARGIACOMO: Objection.
A. The -- we're talking about X now from your hypothetical? I mean, what -- what are we talking about here? Are you saying that there's -- is there -- where does it say in the MedPac report where it would say that they would accept nothing less than a certain amount? It -- I -- I'm sorry. Are we back in the hypothetical or a different question?
Q. Your whole thesis is that in the but-for world a provider who is receiving X in the real world will be willing to do the same work for less than X. What is your basis for that?
A. Well, it's -- it's basic economics that one will essentially provide some product or some service up to the point of its reservation value or its reservation price or its reservation cost. And

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if the acquisition cost of a drug is a certain amount of money and there -- and that's what a -- a provider is paying for that drug, then certainly they're not going to take less than that.

Now, if they're being paid 500 times that or 400 times that, you're saying is there anything in -- in the -- in the Medicare report that I can point to that said that they wouldn't? And I'd have to look closely to see if I can find a sentence like that. I think it -- to say that someone who is -- who is making thousands of percent on a particular purchase would not be willing to take several hundred percent is -- is -- doesn't accord with -- if the reality of the market changed and there is -- and there is information provided and payers can respond to that and will -- are unwilling to pay certain amounts and providers can't get anymore than that and they're still making money on it, as a matter of economics they will continue to accept that much less.

Q. Well, they may accept less for the drug price, but they would want more for the

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administration of the drug. Isn't that what MedPac found?

MR. NOTARGIACOMO: Objection.

A. MedPac and a variety of deponents we've looked at have said that there are a number of things that enter into reimbursement. Services and physician services administration and -- and the pharmaceutical -- the cost of the pharmaceuticals. It is my -- I've been asked to focus on the pharmaceuticals. I've been asked to focus on what the impacts of the alleged fraudulent manipulation are for those prices, and I've been told as a matter of law that that -- that there's not -- that there's not a recourse of allowing a cross subsidization from some overcharge to pay other -- some other amount of money. Now, I haven't -- whether that's necessary or not, I don't know.

Certainly in -- as a matter of economics, if there were enough oncologists out there, if we start hypothesizing how a market could change, if there's enough oncologists out there, payers can -- can negotiate -- and there's information about what

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those acquisition costs are so that they can negotiate with full information and a full understanding, they're going to say, look, I can hire anybody else to give this shot. I can hire a nurse practitioner or whatever would be allowed, and I can -- I know this drug only costs this much. This is all I'm going to give you. And these doctors will compare that to what the other value of their time, and they will come to another equilibrium, but it will be lower than the one that we find under the alleged manipulation.

Q. What is your support for that?

A. Basic.

Q. That certainly didn't happen in the case of Blue Cross Blue Shield of Massachusetts, did it?

A. What didn't happen in the --

Q. They considered lowering the reimbursement rate and decided not to because the oncologists wouldn't go for it.

MR. NOTARGIACOMO: Objection.

A. The --

Q. How do you explain that example?

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A. Well, let's go back and look at it. My recollection of that example was that they considered it, and they decided that at this point they weren't going to do it. Now, that doesn't say to me that they didn't think that the doctors would accept it. Where do -- where does it say in these slides that they say that the doctors would not accept this? Could you point that to me?

Q. Well, do you recall the reasons articulated in the depositions that I showed you yesterday for why Blue Cross Blue Shield of Massachusetts decided not to change its reimbursement structure?

A. I don't necessarily -- I'm not necessarily able to recall whether -- what precise one that we looked at yesterday. I know that there was -- there was deposition testimony about the -- the provider network and -- and keeping it happy or something along those lines. So, it's -- it's clear that payers are interested in keeping providers happy. They don't want to lose providers, but that doesn't mean that -- that -- well, period. That that's

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clear. Now what --
Q. Is --
A. What's --
Q. Isn't it a fact that all the testimony in the case suggests that if you change the reimbursement formula, you're not going to change the total amount that providers receive? They're still going to insist on getting X.
MR. NOTARGIACOMO: Objection.
THE WITNESS: Could you -- could you please repeat that question.
(Question read back.)
THE WITNESS: That's enough. Thank you.
A. All the testimony in the case suggests that providers are not going to accept anything less than what they're getting now? I haven't seen any testimony in the case that suggests that. I've seen testimony in the case that says there's trade-offs, but you're telling me that all the testimony in this case says that they're not going to accept anything less than they're getting now? That's --
Q. Well, can you cite to me any testimony

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which suggests that they would accept anything less than they're getting now?
A. Well, can you cite any -- you're the one that brought it up and said it's all in the testimony. Could you cite one document that shows that they won't take less?
Q. Okay. Well, take a look at the deposition of Robert Farias of Harvard Pilgrim.
MR. EDWARDS: We'll mark this deposition as Exhibit Hartman 052.
(Deposition of Robert Farias marked Exhibit Hartman 052.)
Q. Do you have that in front of you, Doctor Hartman?
A. I do. I'm still finishing up the last strategic slide that we were --
Q. I want to direct your attention to Page 152 of the Farias deposition.
A. Okay. Hang on a second. Let me see who Doctor -- who Mr. Farias or Doctor Farias is. (Witness reviews document.)
Q. Beginning at Line 7.

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A. I'm sorry. I'm still --
Q. "Question: And Harvard Pilgrim doesn't have any knowledge --"
MR. NOTARGIACOMO: Objection. He's still --
A. You can read as you'd like. I'm still -- I'm not ready to turn yet to the page that you want me to turn to. I'm still --
Q. You haven't read this deposition before?
A. I don't remember the details of this deposition if I did read it. Okay, so now you'd like me to look where?
Q. Page 152, Line 7. "Question: And Harvard Pilgrim doesn't have any knowledge about what providers' acquisition costs are, right? Answer: No. Doesn't require them to disclose those. Answer: No. Question: And if it learned that those were higher or lower than it currently thinks they are, that wouldn't change the fact that it reimburses that methodology which is 95 percent of AWP. Answer: Correct. Question: Indeed, if it learned that in a particular instance physicians were

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getting a particular drug at a -- were getting a rebate or a discount from a manufacturer on a particular drug, that wouldn't change the fact that Harvard Pilgrim's standard across-the-board methodology is 95 percent of AWP. Answer: Correct."
Doesn't that suggest to you, Doctor Hartman, that in your but-for world the provider would still get X?
A. The -- no. This suggests a number of things. First of all, the Farias -- I'm -- I'm reading some of his background. I don't know whether he's the person that negotiates with providers in changing the rates or deciding what they are. This could be somebody who has some administrative position and knows that there's a 95 percent of AWP; that's how they reimburse, period; and is told that -- and it doesn't have any idea that acquisition costs are as much below the AWP as they are. But this is a question of -- right now this is they're -- this is what they're paying. It's not saying whether -- whether providers would shift. It's merely saying that they don't -- they don't --